EDMUND G. BROWN JR.
Attorney General of California
LINDA K. SCHNEIDER
Supervising Deputy Attorney General
SHERRY L. LEDAKIS
Deputy Attorney General
State Bar No. 131767
110 West "A" Street, Suite 1100
San Diego, CA 92101
P.O. Box 85266

San Diego, CA 92186-5266
Telephone: (619) 645-2078
Facsimile: (619) 645-2061
*Attorneys for Complainant*

**BEFORE THE**
**BOARD OF REGISTERED NURSING**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

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| In the Matter of the Accusation Against:<br><br>**LOURDES MARIE RODRIGUEZ**<br>**1626 East Redwood Avenue**<br>**Anaheim, CA 92805**<br><br>**Registered Nurse License No. 515121**<br><br>Respondent. | Case No. 2010-40<br><br>**ACCUSATION** |

Complainant alleges:

**PARTIES**

1. Heidi Goodman, (Complainant) brings this Accusation solely in her official capacity as the Assistant Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about August 28, 1995, the Board of Registered Nursing issued Registered Nurse License Number 515121 to Lourdes Marie Rodriguez (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2011, unless renewed.

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## JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

## STATUTORY PROVISIONS

6. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
>
> . . . .

## REGULATORY PROVISIONS

7. California Code of Regulations, title 16, section 1443 states:

> As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

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8. California Code of Regulations, title 16, section 1443.5 states:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

**COST RECOVERY**

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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## FACTS

10. At all times referenced herein, Respondent was employed as a registered nurse at St. Francis Medical Center (SFMC) in Lynwood, California. On or about May 16, 2007, a 64-year-old male was admitted to SFMC and underwent radical neck resection surgery for cancer. The patient was required to be on aggressive respiratory support (via a medical ventilator[1]) and intubation.

11. On June 14, 2007, at 10:14 a.m., following the patient's decline and deterioration, a "Do Not Resuscitate Level III" (DNR) order was written for the patient by his physician. (Level III directs that no CPR would be administered in the event of a cardiac or pulmonary arrest or clinical deterioration.) The patient was ventilator-dependent.

12. On June 14, 2007, Respondent was asked to cover for the patient's primary nurse while she went on a lunch break. Before the primary nurse went on her break, at 1:36 p.m. the patient appeared to be in pain and she administered 2 mg. of morphine sulfate intravenously. The patient's family, who had been at bedside, left at the same time the primary nurse took a 45 minute lunch break. The primary nurse described the patient as responsive with his eyes open at the time she left on her break. The primary nurse gave Respondent a report on the patient before departing on her break; Respondent was aware there was a DNR order for the patient.

13. At approximately 2:10 p.m., the ventilator alarm sounded. Another nurse, Lena, checked the Central Monitor which showed "low sat"[2] on the patient and asked who had responsibility for him. Respondent stated the patient belonged to the primary nurse who was on break, but that Respondent was covering for her. Lena told Respondent that the patient's ventilator alarm was sounding. There was a lengthy discussion/argument between Respondent and Lena regarding which alarm was sounding (the EKG alarm vs. the ventilator alarm).

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[1] A medical ventilator is an automatic machine designed to mechanically move breathable air into and out of the lungs, to provide the mechanism of breathing for a patient who is physically unable to breathe, or breathing insufficiently.

[2] Refers to deoxygenated blood, or cardiology blood with a low $O_2$ saturation relative to blood leaving the lungs. A "low sat" alarm indicates that the patient's blood oxygen level had reached a critically low level.

Respondent told Lena the patient had a DNR order. Respondent did not check the patient until fifteen minutes had elapsed from when the alarm began.

14. Respondent checked the patient at 2:25 p.m. (15 minutes after the alarm first sounded), and discovered the patient had become disconnected from the ventilator. Respondent reconnected the ventilator and reset the alarm. Respondent failed to "bag"[3] the patient after determining he had low oxygen saturations. According to the ventilator's monitoring strip records, at 2:32 p.m. the patient was asystole[4] and was pronounced dead at 2:51 p.m. Respondent made no nursing notes before, during, or after the event.

15. Respondent claimed she did not hear the ventilator alarm because it was set on silent and did not know why.[5] An internal investigation showed that at the time of the incident, the equipment functioned properly and was maintained properly.

## CAUSE FOR DISCIPLINE

**(Incompetence)**

16. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1) of the Code, within the meaning of California Code of Regulations, title 16, section 1443.5 in that on or about June 14, 2007, as described in paragraphs 10-15, above, Respondent performed her nursing functions in an incompetent manner which contributed to a patient's death as follows:

a. Respondent failed to timely respond to a critical ventilator alarm in a patient who was known to be ventilator dependent and who received morphine, a respiratory depressant, 30 minutes prior to the alarm sounding;

b. When Respondent discovered the patient was showing symptoms of respiratory distress, as evidenced by his low oxygen saturations, Respondent went to troubleshoot the ventilator first instead of performing manual respiration on the patient via a flexible reservoir bag;

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[3] An "Ambu bag" is the trade name for a flexible reservoir bag connected by tubing and a non-rebreathing valve to a face mask or endotracheal tube and is used for manual artificial ventilation. It is self-inflating with room air or from an oxygen source.

[4] Asystole is a dire form of cardiac arrest in which the heart stops beating -- there is no systole -- and there is no electrical activity in the heart.

[5] Ventilators are designed to have alarms that stay activated at all times. A clinician can temporarily silence the alarms for short periods (ie. 20 seconds), however, the alarms reset automatically.

c. Respondent failed to chart the patient's condition before, during, or after she responded to the ventilator alarm;

**PRAYER**

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 515121, issued to Lourdes Marie Rodriguez;

2. Ordering Lourdes Marie Rodriguez to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 7/27/09

Heidi Goodman,
Assistant Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
*Complainant*

SD2009804546